TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STRATUS ANESTHESIA ASSOCIATES OF DALLAS, PLLC

Respondent Name
STAR INSURANCE COMPANY

MFDR Tracking Number
M4-16-1158-02

Carrier's Austin Representative
Box Number 48

MFDR Date Received
January 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has issued a payment for our service but not the correct allowable per the 2015 Texas Workers Compensation fee schedule."

Amount in Dispute: $63.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

TX follows CMS for reimbursement and guidelines
Medicare Claims Processing Manual: Chapter 12 – Physicians/Nonphysicians Practitioners: . . .

140.3 - Anesthesia Fee Schedule Payment for Qualified Nonphysician Anesthetists
For services furnished on or after January 1, 1996, the fee schedule for anesthesia services furnished by qualified nonphysician anesthetists is the least of 80% of:

- The actual charge;
- The applicable locality anesthesia conversion factor multiplied by the sum of allowable base and time units. . . .

01400/QX.P2 4 base + 8 time = 12 * 56.20 = $674.40 * 50% (modifier QX) = $337.20 * 80% = $269.76
Bill is priced correct per CRNA reimbursement.

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2015	Certified Registered Nurse Anesthetist (CRNA) Anesthesia Services	$63.79	$63.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P5 – [No description of this payment reduction code was found with the submitted materials.]
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. What is the rule for reimbursement of the disputed anesthesia services?
2. Does Medicare policy require a 20% payment reduction from the anesthesia fee schedule for CRNA services?
3. What is the maximum allowable reimbursement (MAR) for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards professional medical services of a Certified Registered Nurse Anesthetist (CRNA) with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

   > To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . . .
   >
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2015 is $56.20.

2. The requestor maintains the insurance carrier has not applied the correct allowable per the 2015 Texas Workers Compensation fee schedule.

   Rule §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The respondent asserts that per Medicare payment policy, the fee schedule for anesthesia services furnished by qualified nonphysician anesthetists is the least of 80% of the actual charge or the applicable locality anesthesia conversion factor multiplied by the sum of allowable base and time units. In support of which, the respondent cites *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 12 - Physicians/Nonphysician Practitioners, §140.1, regarding Qualified Nonphysician Anesthetists, and §140.3, regarding Anesthesia Fee Schedule Payment for Qualified Nonphysician Anesthetists.

   Review of *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 12 - Physicians/Nonphysician Practitioners, §140 – "Qualified Nonphysician Anesthetist Services" finds that the respondent's position is not supported; the insurance carrier has failed to read the entirety of the section and has interpreted the application of the policy out of context.

Section 140 states that:

> Anesthesia services are subject to the usual Part B coinsurance and deductible and . . . For services furnished after January 1, 1996, when separate conversion factors for CRNAs were eliminated, anesthesia services furnished by a qualified nonphysician anesthetist are paid at the lesser of the actual charge, the physician fee schedule, or the anesthesia fee schedule.

Subsection 140.3 further states that:

> Services furnished by qualified nonphysician anesthetists are subject to the Part B deductible and coinsurance. If the Part B deductible has been satisfied . . .
>
> For services furnished on or after January 1, 1996, the fee schedule for anesthesia services furnished by qualified nonphysician anesthetists is the least of 80 percent of:
>
> - The actual charge;
> - The applicable locality anesthesia conversion factor multiplied by the sum of allowable base and time units.

When read in the greater context of this section, it becomes clear that the 20% payment reduction is for the patient's coinsurance portion under the Medicare program. The *allowed amount* for CRNA services (after the patient's Medicare deductible has been met) is the lesser of 100% of the actual charge or 100% of the anesthesia fee schedule (that is, the conversion factor multiplied by the sum of the base and time units) and of that allowed amount, Medicare pays 80% to the provider — leaving a 20% coinsurance remaining as patient responsibility. However, there is no patient responsibility in the Texas Workers' Compensation system; therefore, no coinsurance is deducted from the workers' compensation reimbursement to the provider.

Accordingly, the Division finds that Medicare payment policy does not require a 20% payment reduction from the anesthesia fee schedule for CRNA services. *Medicare Claims Processing Manual*, Chapter 12, §140 makes clear that after January 1, 1996, when separate conversion factors for CRNAs were eliminated, the anesthesia fee schedule allowance is the same for all qualified anesthesia providers — regardless of specific credentialing; CRNAs and AAs are paid the same as physician anesthesiologists. A workers' compensation insurance carrier is thus responsible for paying the full 100% of the fee schedule allowed amount to the CRNA — substituting the applicable Division conversion factor multiplied by the allowable base and time units to determine the MAR.

3. Reimbursement is calculated as follows:
   - The provider billed this service with modifier QX. Per *Medicare Claims Processing Manual*, Chapter 12, §140.4.2 – Qualified Nonphysician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure:

     > Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed qualified nonphysician anesthetist, and the service is furnished on or after January 1, 1998, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. The modifier to be used for current procedure identification is QX.

     Accordingly, the Medicare fee schedule amount must be reduced by 50% for use of the QX modifier.
   - Review of the anesthesia record finds that 118 minutes of anesthesia care were provided.
   - Per *Medicare Claims Processing Manual*, Chapter 12 - Physicians/Nonphysician Practitioners, §50. G - "Anesthesia Time and Calculation of Anesthesia Time Units," time units are computed by dividing reported anesthesia time by 15 minutes, rounding to one decimal place.
   - 118 minutes ÷ 15 = 7.9 time units.
   - Anesthesia code 01400 has a base unit value of 4.

     (A list of anesthesia base unit values is publically available at the Centers for Medicare and Medicaid Services website at https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html)
   - The sum of the base units (4) and time units (7.9) totals 11.9, reduced by 50% (due to the QX modifier) equals 5.95, multiplied by the Division's 2015 conversion factor of $56.20 results in a MAR of $334.39.
4. The total allowable reimbursement for the services in dispute is $334.39. The insurance carrier has paid $269.76. The requestor is seeking $63.79. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $63.79.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $63.79, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 21, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.